| King County | Department of Adult and Juvenile Detention<br>All Divisions<br>General Policy Manual | |
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| | **Chapter 3**<br>**Safety and Emergency Procedures** | |
| **3.02.014, Death Investigations, Administrative Reviews and Inquests** | Approved By: | Director Allen Nance |
| | Effective Date: | May 09, 2024 |
| | Reviewed By: | PRC, PAO, IIU Commander |
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**Purpose**
To establish procedures for jail resident/detained youth death investigations, administrative reviews and inquests.

**Policy**
It is the policy of the Department of Adult and Juvenile Detention that all jail resident/detained youth deaths be investigated, administratively reviewed and that the Department of Adult and Juvenile Detention fully cooperate with inquests.

**References**

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| Federal: | Occupational Safety & Health Administration (OSHA) Rules and Regulations for Occupational Exposure to Bloodborne Pathogens. 29 CFR 1910.1030: Occupational Exposure to Bloodborne Pathogens. |
| RCW: | 43.102 Office of Independent Investigation<br>49.17 Washington Industrial Safety and Health Act<br>70.48.510 Unexpected Fatality Review |
| WAC: | 296-27, Record Keeping and Reporting<br>296-823, Occupational Exposure to Bloodborne Pathogens |
| PHSKC: | Exposure Control Plan |
| DAJD Policies: | 1.03.010, Peer Support and Critical Incident Response<br>3.01.001, Exposure Control Plan for Bloodborne Pathogens<br>3.02.004, Emergency Response<br>3.02.018, Jail Freeze and Lockdown<br>4.01.021, Evidence Collection and Storage<br>4.01.023, Video Recordings<br>4.03.014, Use of Force<br>7.03.002, Sanitation of Housing Units<br>J-AP-2.005-2023, Critical Incident Operational Review<br>J-CepP-9.000-2017, Emergency Action Plan<br>J-CepP-9.001-2020, Code Blue Emergency<br>J-CepP-9.001-2017, Code Response<br>J-CepP-9.000-2019, All Emergency Situations |

DAJD Forms: Supervisor's Incident Report
Officer Report
Close Observation Check Log (F-766)
Resident/Patient Death Notification (F-312)

## Definitions

**Deadly Force:** The intentional application of force through the use of firearms or any other means reasonably likely to cause death or serious physical injury.

**In-custody Death:** Any jail resident/detained youth death that occurs inside the King County Correctional Facility (KCCF), Maleng Regional Justice Center (MRJC) or the Clark Children and Family Justice Center (CCFJC), or while the jail resident/detained youth is at court, a medical appointment, in "4999" or "R999" status or has been temporarily checked out by a secondary law enforcement agency.

**Inquest:** An inquiry into and review of the manner, facts and circumstances of the death of an individual where an action, decision or possible failure to offer the appropriate care by a member of any law enforcement agency (to include the department and Jail Health Services) might have contributed to an individual's death.

**Investigators:** Staff from the Office of Independent Investigation, the Seattle Police Department (SPD), the Kent Police Department (KPD), the Medical Examiner's (ME) Office or from other local law enforcement agencies that is responsible for the investigation of an in-custody death.

**Office of Independent Investigation:** An investigative law enforcement agency statutorily authorized to investigate uses of deadly force by DAJD staff.

**Special Investigations Unit:** A department unit consisting of sergeants who report to the Internal Investigations Unit Commander, see policy 1.05.001, Special Investigations Unit.

**Unexpected Death:** Any in-custody death that was not the result of a diagnosed or documented terminal illness or other debilitating or deteriorating illness or condition where the death was anticipated.

## A. General Guidelines

1. In-custody deaths that result from the intentional use of deadly force by DAJD staff shall be reported to OII in accordance with policy 4.03.014, Use of Force. The OII contact information is located on the EDO call list and the EDO shall be responsible for notifying OII.
   a. If OII indicates that it will investigate the in-custody death, OII shall become the lead investigative body.
   b. If OII indicates that it will not investigate the use of deadly force, the in-custody death shall be investigated by an independent investigation team or the local law enforcement agency that has jurisdiction.
2. In-custody deaths that were not the result of the use of deadly force will be investigated by the Seattle Police Department (SPD) or the Kent Police Department (KPD), pursuant to their respective Memorandum of Understanding (MOU), or the local law enforcement agency that has jurisdiction.
3. Whenever there is an in-custody death, the department will immediately inform the King County Prosecuting Attorney's Office (PAO) Public Integrity Team and the King County Inquest Program Manager. The KCPAO Public Integrity Team contact information is located on the EDO contact list.

4. In addition to the investigation of in-custody deaths conducted by a law enforcement agency, as described above, the department will also conduct an administrative review of all in-custody deaths in accordance with Section E below.
5. If the local law enforcement declines to investigate the in-custody death and has determined a crime has not occurred, SIU will conduct the death investigation in accordance with this policy.
6. If a jail resident/detained youth dies while in a medical facility, the officer assigned to the jail resident/detained youth shall notify their sergeant/supervisor, who will notify the shift commander/Chief of Operations or designee. The shift commander/Chief of Operations is responsible for notifications in section D.4.
7. If a jail resident/detained youth, that is in critical condition, is released from all holds while a patient at a medical facility, the Shift Commander or designee will complete a Patient Death Notification form and the form will be delivered to the medical facility.
8. Staff will refer all inquiries about in-custody deaths to the Public Information Officer (PIO).
9. The Director and the PIO are the only DAJD personnel authorized to discuss or disclose information regarding jail resident/detained youth deaths with the next-of-kin/family/family representative.

## B. Law Enforcement Investigation

1. Whenever an in-custody death is investigated by Investigators, the department will not be directly involved in their investigation, except as provided below.
2. Once Investigators arrive at the scene of the in-custody death, DAJD shall relinquish control of the scene to them and will not participate in the investigation except to:
    a. Secure the scene and preserve evidence until the Investigator takes charge of the scene, to include:
        1) Physical evidence that is at risk of being destroyed or disappearing and cannot be easily reconstructed, including evidence which may be degraded or tainted by human or environmental factors if left unprotected or unpreserved;
        2) Identification and contact information for witnesses to the incident; and
        3) Photographs and other methods of documenting the location of physical evidence and the location and perspective of witnesses.
    b. If requested by Investigators, providing specialized equipment that is necessary for the investigation and where no alternative exists.
    c. Gathering relevant records about the deceased jail resident/detained youth to be provided to the Investigators (the Investigators shall have access to reports and information necessary or related to the investigation, including but not limited to, voice or video recordings, body camera recordings, and office notes, as well as disciplinary and administrative records except those that might be statements conducted as part of an administrative investigation related to the incident),
    d. Assigning a SIU sergeant to assist the Investigators as requested.
3. All staff are expected to be available for interview requests from Investigators.

4. Securing the deceased jail resident/detained youth's property following the appropriate department policies (at the Adult Divisions: 5.05.001, Resident Property Room and Storage).
5. Freezing the deceased jail resident/detained youth's trust fund account.
6. Prior to the Investigator departing the scene, the duty sergeant shall verify that the Investigator has concluded their investigation and whether DAJD is able to take control of the scene, interview staff and begin the administrative review process.
7. Analysis of suspected suicide scenes and notes will only be processed and handled by the responding Investigator(s).
8. The Division Major/Chief of Operations or their designees shall provide the Investigators with the following information:
    a. Names and contact information for:
        1) Responding Emergency Medical Services (EMS) staff, uniformed staff, and Jail Health Services (JHS) staff or the medical staff at the Juvenile Division.
        2) Known medical or psychiatric providers.
        3) Residents/detained youths housed in the same location or near the decedent.
        4) Who discovered the body.
    b. Arrival and departure times for EMS staff, uniformed staff, and JHS staff.
    c. When and where the body was discovered.
    d. Specific information about:
        1) Administration of Cardio-Pulmonary-Resuscitation (CPR).
        2) Use of an Automatic External Defibrillator (AED).
        3) Any known medication administered.
        4) Any known movement of the body by first responders.
        5) Any known marks left on the body due to life-saving attempts.
    e. A description of the body and the surrounding area, including:
        1) Position of the body when it was discovered.
        2) Obvious wounds and/or injuries.
        3) Blood or other bodily fluid stains on the deceased jail resident/detained youth's uniform or surrounding area.
        4) Whether uniforms or linens were torn.
        5) Condition of the room (signs of a struggle, etc.).
        6) Anything out of the ordinary.
    f. The deceased jail resident/detained youth's:
        1) Name and date of birth.
        2) Booking Arrest (B/A) number or Universal Control Number (UCN).
        3) Address and phone number.
        4) Emergency contact name and contact information.
    g. Any relevant information, documentation, or records not identified above, which pertains or could pertain to the investigation.

## C. Special Investigations Unit Investigations

1. In the event the local enforcement declines to conduct an investigation, SIU will complete the death investigation.
2. The SIU sergeant shall:
    a. Take photographs and video of the scene as applicable.

b. Gather and package any evidence, following policy 4.01.021, Evidence Collection and Storage.
c. Preliminary testing of any unknown substances using the appropriate technology.
d. Interview or obtain statements from witnesses and all involved staff.
e. Notify the Medical Examiner upon completion of processing the scene.
f. Collect the booking packet and photocopy the contents for the duty sergeant and other Investigators.
g. Forward the booking packet as required.
h. Ensure all appropriate facility video has been captured.
i. Notify accounting to place a freeze on the deceased jail resident/detained youth's monetary account.
j. For the Adult Division, ensure the deceased jail resident's property is handled following policy 5.05.001, Resident Property Room and Storage.
k. Gather all of the deceased jail resident's/detained youth's communication records (i.e., phone calls, video visits, messages, etc.)
l. Collect JMS records and reports relating to the deceased jail resident/detained youth.

**D. DAJD Staff Responsibilities when Responding to an In-Custody Resident/Detained Youth Death**

1. The officers shall:
   a. Follow the divisions emergency response policies when responding to and once at the scene.
   b. Begin an incident log (refer to Section B.8. for information to include as well as a list of all persons entering the crime scene).
   c. Secure the location.
   d. Do not move or cover the body. The area is considered part of a crime scene. Until the scene has been released to DAJD, only Investigators and SIU, if they are conducting the investigation, may enter (after the initial emergency response) or remove items from the scene.
   e. Submit reports as required.
2. The duty sergeant/supervisor shall:
   a. Respond to the scene immediately and assume command until Investigators or SIU takes over the scene.
   b. Assess the situation and ensure that appropriate response is in progress.
   c. Ensure that:
      1) An officer has started an incident log.
      2) At a minimum, freeze the unit/wing/area and access to the immediate area is only granted to Investigators, until the scene has been relinquished to DAJD.
      3) Jail residents/detained youths are removed from the housing unit/tank/area where the death occurred and are isolated until each one has been interviewed by the Investigators or SIU. This may require using areas in different parts of the facility.
   d. Maintain communications with the shift commander/appropriate supervisor.
   e. Provide information to the Investigator(s) or SIU as requested.

f. After the body has been removed and the area has been released by the Investigators or SIU, ensure the place of death and surrounding area has been cleaned and sanitized in accordance with department policy.
g. Secure copies of any paper documents that may not be captured in JMS.
h. Restore the area to normal operations once the scene has been released by Investigators and/or any DAJD specific investigative steps have been taken.
i. Print the shift roster and shift notes for the incident.
j. Complete a Supervisor Incident Report, collect all other reports and forward all reports to the appropriate shift commander or supervisor prior to the end of shift (shift extension may be required).
k. Forward a copy of all paperwork to the appropriate shift commander.

3. When possible, the ITR sergeant shall:
   a. Close the decedents booking only when instructed to do so by the Division Major/Deputy Division Director.
   b. Inform the appropriate courts and contracting agencies (i.e., DOC) of the jail resident/detained youth's death.
4. The shift commander/supervisor shall:
   a. In the case of a death at a hospital, provide the deceased jail resident/detained youth's emergency contact information to the hospital staff, if requested.
   b. Ensure the ME local law enforcement and the IIU commander are notified of the death, if after hours contact the executive duty officer (EDO) or the Officer of the Day (OD).
   c. Review and forward reports to the Division Major/Chief of Operations.
   d. Contact the Peer Support Coordinator following policy 1.03.010, Peer Support and Critical Incident Response.
   e. Coordinate/delegate the completion of appropriate documentation, updating files and records where applicable.
   f. Preserve all applicable video recordings as indicated by department policy 4.01.023, Video Recordings.
   g. During business hours, notify the Division Major/Division Deputy Director.
   h. After business hours, notify the EDO or OD.
5. During normal business hours, the Major/Deputy Division Director will notify:
   a. The Facility Commander/Division Director
   b. Director (who will contact the King County Executive's Office)
   c. JHS Director and Deputy Director, JHS Medical Director and the JHS Accreditation Manager.
6. The EDO or OD will make the following notifications (after business hours):
   a. Facility Commander, Juvenile Division Director or CCD Director, if applicable.
   b. Director (who will notify the King County Executive's Office).
   c. JHS Director and Deputy Director, JHS Medical Director and the JHS Accreditation Manager.
   d. King County PAO Public Integrity Team
   e. King County Inquest Program Manager (via email)
7. The major, EDO, Juvenile Division Director or CCD Director shall:
   a. Ensure notifications have been made to:
      1) King County PAO Public Integrity Team
      2) King County Inquest Program Manager (via email).

b. Ensure emotional assistance is provided to any staff member(s) affected by the incident.
c. Contact and inform the PIO of the situation, as necessary.
d. Contact the president or legal advisor of any affected labor organization and inform them of the situation, as appropriate.
e. Ensure that all reports are made available to the investigating agency, once they are completed and approved.
f. Review, approve, and forward all reports to the Director via the Chain of Command.
g. Ensure SIU has been provided a copy of the final incident packet with all the appropriate signatures.
h. Identify any critical issues/risks that require immediate attention. An Immediate Action Plan is developed and implemented to address any issues/risks that are identified. Timelines for addressing the concerns presented are identified in the action plan. DAJD and JHS/PH shall share and collaborate on implementation of action plans as needed.

8. The PIO shall contact and brief the King County director of communications on the situation.
9. The Director's Office shall:
   a. The Director or designee shall follow up and notify the next-of-kin/family/family representative of the death and to offer to schedule a "next of kin" meeting to answer any questions they may have.
   b. Coordinate the DAJD/JHS briefing of the King County Executive within 24-hours of the in-custody death.
   c. Coordinate the press releases, other public and internal communications with JHS. All releases will be sent out concurrently; it is anticipated this information will be distributed within 24-hours of the death unless further coordination is required with a potential investigating agency.
   d. Facilitate/schedule the "next of kin meeting" (this contact should occur within 24 hours of the death notification). Invite the appropriate Facility Commander, Juvenile Division Director or CCD Director, JHS Medical Director, and the JHS Director or Deputy Director.
   e. Attend the 'next-of-kin meeting'. This meeting should occur as soon as the next-of-kin/family/family representative is available to meet.
   f. Provide the next-of-kin/family/family representative with information outlining support services and release of information data for all agencies involved in the decedent's care.
   g. Approve the release of any of the deceased jail resident/detained youth's personal belongings that were not retained as part of the investigation or the administrative review to the next-of-kin/family/family representative in accordance with state law (RCW 11.62).

## E. Administrative Reviews of In-Custody Deaths

1. DAJD will conduct an administrative review of all in-custody deaths that will be conducted separately from any law enforcement death investigation.
2. The purpose of the administrative review is:
   a. Determine if any policy changes are warranted.

   b. Determine if any policies were violated that would require an IIU investigation.
   c. Gather information needed for the DAJD/JHS Critical Incident Review.
   d. Gather information needed to complete the Unexpected Fatality Review.,
3. The administrative review will be overseen by SIU/IIU investigators as assigned by the IIU Commander.
4. The administrative review will not interfere with the law enforcement investigation.
5. The administrative review shall begin as soon as possible after the in-custody death.
6. IIU/SIU interviews should be held in abeyance until any necessary interviews have been conducted by the Investigators, if applicable.

## F. Unexpected Fatality Reviews

1. In any case where the death of a jail resident/detained youth is unexpected, DAJD shall convene an unexpected fatality review team and conduct an unexpected fatality review.
2. The unexpected fatality review team shall consist of staff members whose professional expertise is pertinent to the case and who have no previous involvement in the case.
3. The unexpected fatality review shall include an analysis of the root cause or causes of death, and an associated corrective action plan to address identified root causes and recommendations made by the unexpected fatality review team.
4. The purpose of the unexpected fatality review team is to present recommendations to the Executive's Office and the King County Council regarding needed changes to policy or procedure to prevent fatalities and strengthen safety and health protections for individuals in custody.
5. Upon completion of the unexpected fatality review, DAJD shall, within 120 days of the jail resident/detained youth death, provide a report on the results of the review to the Executive's Office, the King County Council and the Washington State Department of Health, unless an extension has been granted by the Executive's Office.

## G. Timelines for Administrative Reviews of In-Custody Deaths

1. Within 24 business hours:
   a. DAJD and JHS/PH representatives shall jointly prepare a briefing and meet with the King County Executive.
2. Within 1 Week DAJD and JHS/PH shall:
   a. Provide updates to the King County Executive's Office that contains any new information.
   b. Provide the Immediate Action Plan to the County Executive and describe and steps taken under the plan if required.
3. Within 30 Days:
   a. They shall hold a Post Incident Review.
   b. The Department shall make reports available for review by JHS.
   c. A DAJD liaison shall participate in the JHS Critical Incident Review.
   d. At the Juvenile Division, a separate Critical Incident Review will take place with the appropriate medical staff.

4. Upon completion of the DAJD Post Incident Review and JHS/PH CIR, DAJD shall coordinate with JHS to jointly report the findings and status to the King County executive describing the findings of the reviews, the status of the action plans, and any actions taken to date if required.
5. Within 60 Days:
   a. DAJD and the JHS/PH shall separately revisit progress made under the respective Post Incident Review/Immediate Action Plans. They shall also review the status of any additional actions suggested by the Post Incident Review and JHS Critical Incident Review.
6. Within 100 days:
   a. Provide a report to the King County Executive about the status of the administrative review and the Unexpected Fatality Review.
7. Within 120 days (unless an extension has been granted by the Executive's Office):
   a. Provide a report on the results of the review to the Executive's Office, the King County Council and the Washington State Department of Health.
8. Once the administrative review has been completed, the completed file will be sent to the IIU Commander for filing.

## H. Inquests

1. If the department is informed that an inquest will be conducted, the department shall fully cooperate with the inquest process in accordance with the above referenced Executive Order.
2. Once the department learns of an inquest, it shall designate an official to provide a comprehensive overview of the forensic investigation into the death, to include, but not be limited to:
   a. Statements collected by investigators.
   b. Investigator's review of forensic evidence.
   c. Physical evidence collected by investigators.
3. The Department Director (or designee) shall be available to provide testimony concerning training and policy as they relate to the death.